DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-38	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2003	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447 Subpart C	a. FFY 2003 ($1,956.11) b. FFY 2004 ($1,938.76)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-A, Item 1, Page 7 Attachment 4.19-A, Item 1, Page 7.a.	Same (TN 02-21) None (New Page)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement for inpatient services rendered in private (non-state) acute hospitals, including long term hospitals. This action is necessary in order to avoid a budget deficit in the medical assistance programs.**

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

■ OTHER, AS SPECIFIED: **The Governor does not review state plan material**

12. SIGNATURE OF STATE AGENCY OFFICIAL: David W Hood	16. RETURN TO:
13. TYPED NAME: David W. Hood	State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
14. TITLE: Secretary	
15. DATE SUBMITTED: December 9, 2003	

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17. DATE RECEIVED: DEC 17 2003	18. DATE APPROVED: FEB 17 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Bruce W. Smith
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO

23. REMARKS:

RECEIVED
REGION VI-DALLAS
HCFA/MOFMB

FORM HCFA-179 (07-92)

Step 2 - Supplementation.
Operating cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994), then arrayed by peer group from high to low to determine the weighted median cost for the peer group. In peer groupings with less than three facilities, the median is used. In the case of a group with only one facility, the facility-specific cost is used. For those hospitals below the weighted median, the operating cost was supplemented by 25% of the difference between the hospital-specific cost per day and the median cost per day for the peer group.

Step 3 - Cap calculation.
Operating cost for each hospital as determined in Step 2 was arrayed by peer group from high to low to determine the weighted median cost for the peer group. Operating cost for each hospital/unit above the weighted median was capped at the weighted median. Exception: Long term hospitals are capped at the 30th percentile facility as reported on the as-filed cost report for the hospital cost report year ending between July 1, 1995 through June 30, 1996.

Step 4 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group weighted median and 30% of the hospital-specific component (as supplemented in Step 2 and capped in Step 3).

Step 5 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (as supplemented in Step 2 and capped in Step 3) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals/units in the group.

Step 6 - Determination of hospital-specific component.
Each hospital's operating cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.
Costs are inflated for each subsequent non-rebasing year.

6. Calculation of Payment Rates
Individual facility rates are calculated annually by adding together the four components listed above for each facility.

Effective for dates of service on or after October 1, 2003 inpatient services rendered in

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHOD AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

private (non-state) acute hospitals, including long term hospitals, with a Medicaid utilization rate of less than 25 percent shall be reimbursed as follows: in state fiscal year 2003-2004 only, the reimbursement shall be 98.75 percent (a 1.25 percent reduction) of the per diem rates in effect on September 30, 2003, and for subsequent years, the reimbursement shall be 99.2 percent (a .8 percent reduction) of the per diem rates in effect on September 30, 2003 for private hospitals.

The Medicaid inpatient days utilization rate shall be calculated based on the filed cost report for the period ending in state fiscal year 2002 and received by the Department prior to April 30, 2003. Only Medicaid covered days for inpatient hospital services, which include newborn days and distinct part psychiatric units, are included in this calculation. Inpatient stays covered by Medicare Part A can not be included in the determination of the Medicaid inpatient days utilization rate. Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) shall be excluded from this reimbursement reduction. Also inpatient services provided to fragile newborns or critically ill children in either a Level III Regional Neonatal Intensive Care Unit or a Level I Pediatric Intensive Care Unit, which units have been recognized by the Department on or before January 1, 2003, shall be excluded from this reimbursement reduction.